



**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	CareNet Pregnancy Center of Northeast Connecticut	
Doing Business As	Caring Families Pregnancy Services	
Name of Parent Corporation	N/A	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	157 Main St. Danielson, CT 06239	
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP	
Name of Contact person, including title	Linda Hayes, RN Executive Director	
Contact person's street mailing address	157 Main St. Danielson, CT 06239	
Contact person's phone, fax and e-mail address	(860) 779-0218 phone (860) 779-0864 fax caringfamilies@juno.com	

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2005 JAN -3 PM 2:08
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:

Care Net Pregnancy Center of Northeast Connecticut

b. Location of proposal (Town including street address):

157 Main St. Danielson, CT 06239

c. List all the municipalities this project is intended to serve:

Northeast Connecticut: Woodstock, Thompson, Putnam, Brooklyn, Killingly, Canterbury, Plainfield, Moosup, Pomfret, Eastford

d. Estimated starting date for the project:

December 2005e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E P

☐ ☐ Acute Care Hospital☐ ☐ Behavioral Health Provider☐ ☐ Hospital Affiliate

E P

☐ ☐ Imaging Center☐ ☐ Ambulatory Surgery Center☐ ☐ Other specify):

E P

☐ ☐ Cancer Center☐ ☒ Primary Care Clinic**SECTION III. EXPENDITURE INFORMATION**a. Estimated Total Capital Expenditure/Cost: \$ 30,500

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations

\$ 4,000

Medical Equipment (Purchase)

Imaging Equipment (Purchase)

\$ 25,000

Non-Medical Equipment (Purchase)

\$ 1,500

Sales Tax

Delivery & Installation

Included**Total Capital Expenditure**

\$0.00

Fair Market Value of Leased Equipment

N/A

Total Capital Cost

\$0.00

Major Medical and/or imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit	
Biosound	Esate	260	Corvus	1	\$25,000

Note: Provide copy of contract with vendor for medical equipment.

c. Type of financing or funding source:

- | | | |
|--|---|---|
| <input type="checkbox"/> Operating Funds | <input type="checkbox"/> Lease Financing | <input type="checkbox"/> Conventional Loan |
| <input checked="" type="checkbox"/> Charitable Contributions | <input type="checkbox"/> CHEFA Financing | <input checked="" type="checkbox"/> Grant Funding |
| <input type="checkbox"/> Funded Depreciation | <input type="checkbox"/> Other (specify): | |

SECTION IV. PROPOSAL DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

See attached

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

PROPOSAL FOR PRIMARY CARE CLINIC
CARENET PREGNANCY CENTER OF NORTHEAST CONNECTICUT
157 Main St. Danielson, CT 06239

Care Net Pregnancy Center of Northeast Connecticut is a non-profit organization that offers services such as self-administered pregnancy testing, counseling, parenting & childbirth classes, and material assistance to women who have pregnancy-related issues. There is no Department of Public Health license, as we currently do not serve as a medical facility.

The services that CareNet Northeast would like to provide are medical services such as pregnancy testing, medical consultation and referral and limited obstetrical ultrasound. We would seek a category of primary care clinic from the DPH.

There will be no charge to clients for services provided.

The current population served is and will be primarily women ages 16 through 40, who would be in various stages of pregnancy, mostly in the first trimester. The area of service covers all of Windham County, which has the highest teen pregnancy rate of any county in the state, and has a large percentage of low income people who do not have access to affordable, available primary care services.

The service would be provided by a board certified Medical Director, RDMS-certified ultrasound technicians, and a Nurse Manager.

The payers for this service would be donors to the non-profit organization and grants, as all services are offered free to clients.

SECTION V. AFFIDAVITApplicant: LINDA HAYESProject Title: CARE NET PREGNANCY CENTER OF NECTI, LINDA HAYES, CEO
(Name) (Position – CEO or CFO)of BOZRAH being duly sworn, depose and state that theinformation provided in this CON Determination form is true and accurate to the best of my
knowledge, and that CARE NET
PREG CNTR OF NECT complies with the appropriate
(Facility Name)

and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Linda Hayes
Signature12-30-04
DateSubscribed and sworn to before me on December 30-2004Dom Hong
Notary Public/Commissioner of Superior CourtMy commission expires: My Commission Exp. Sep. 30, 2008



STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

July 22, 2005

CRISTINE A. VOGEL
COMMISSIONER

Ms. Linda Hayes, RN
Executive Director
CareNet Pregnancy Center of Northeast Connecticut
157 Main Street
Danielson, CT 06239

RE: Certificate of Need Determination; Report Number 05-30425-DTR
CareNet Pregnancy Center of Northeast Connecticut d/b/a
Caring Families Pregnancy Services
Establish CareNet Pregnancy Program in Danielson

Dear Ms. Hayes:

On January 3, 2005, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the proposal of CareNet Pregnancy Center of Northeast Connecticut to establish a pregnancy program located at 157 Main Street in Danielson, CT, at a total capital expenditure of \$30,500. On July 21, 2005, OHCA received a letter from the Department of Public Health regarding the request for exemption from the CON process, pursuant to Section 19a-639b of the Connecticut General Statutes.

OHCA has reviewed the information contained in the request and makes the following findings:

1. CareNet Pregnancy Center of Northeast Connecticut ("CareNet") is a non-profit organization that offers services such as pregnancy testing, counseling, parenting and childbirth classes, and material assistance to women who have pregnancy-related issues.
2. CareNet proposes to provide medical services such as pregnancy testing, medical consultation and referral and limited obstetrical ultrasound free of charge at 157 Main Street in Danielson, CT.
3. CareNet is proposing to serve women ages 16-40 who would be at various stages of pregnancy who reside in Windham County.
4. CareNet will seek to be licensed as a primary care clinic.
5. The Department of Public Health stated in its letter that an exemption could not be recommended due to the inability to ascertain documentation identifying a need for the proposal in the proposed area.

An Equal Opportunity Employer

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308

Telephone: (860) 418-7001 • Toll free (800) 797-9688

Fax: (860) 418-7053

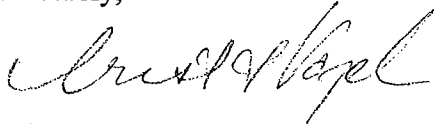
6. CareNet is a health care facility or institution as defined in Section 19a-630 of the Connecticut General Statutes ("C.G.S.").
7. The total capital expenditure for the proposal is \$30,500.

Based on the above findings, OHCA has determined that CareNet, a health care facility or institution, is required to seek and obtain Certificate of Need approval to establish a pregnancy program at 157 Main Street in Danielson, CT, pursuant to Section 19a-638 of the Connecticut General Statutes.

OHCA considers the submission of additional information received on July 19, 2005 from the Department of Public Health as the Letter of Intent for this matter; therefore CareNet may file a completed CON application with OHCA between September 19, 2005, and November 16, 2005. The CON application is attached.

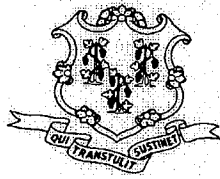
If you have any questions regarding the above, please contact Paolo Fiducia, Associate Health Care Analyst at (860) 418-7035.

Sincerely,



Cristine A. Vogel
Commissioner

Copy: Rose McLellan,, License and Applications Supervisor, DPH



State of Connecticut Office of Health Care Access Certificate of Need Application

Please complete all questions. If any question is not relevant to your project *Not Applicable* may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than September 19, 2005, and may be submitted no later than November 16, 2005. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 05-30425-CON

Applicant(s) Name: CareNet Pregnancy Center of Northeast Connecticut

Contact Person: Linda Hayes, RN
Contact Title: Executive Director
CareNet Pregnancy Center of Northeast Connecticut

Contact Address: 157 Main Street
Danielson, CT 06239

Project Location: Danielson

Project Name: Establish a Pregnancy Program

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: \$30,500

1. Expansion of Existing or New Service

What services are currently offered at your facility(ies) that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

Replace: _____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:

- a) Primary and secondary service area towns
- b) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic information, as appropriate.
- c) Hours of operation of existing/proposed service

ii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

- | | |
|--|---|
| <input type="checkbox"/> Cultural | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Geographic | <input type="checkbox"/> Economic |
| <input type="checkbox"/> None of the above | <input type="checkbox"/> Other (Identify) _____ |

If you checked other than None of the above, please provide an explanation.

- C. Provide copies of any of the following plans, studies or reports related to your proposal:

- | | |
|---|--|
| <input type="checkbox"/> Epidemiological studies | <input type="checkbox"/> Needs assessments |
| <input type="checkbox"/> Public information reports | <input type="checkbox"/> Market share analysis |
| <input type="checkbox"/> Other (Identify) _____ | |

5. Quality Measures

- A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

- | | | |
|---|--|--|
| <input type="checkbox"/> American College of Cardiology | <input type="checkbox"/> National Committee for Quality Assurance | <input type="checkbox"/> Public Health Code & Federal Corollary |
| <input type="checkbox"/> National Association of Child Bearing Centers | <input type="checkbox"/> American College of Obstetricians & Gynecologists | <input type="checkbox"/> American College of Surgeons |
| <input type="checkbox"/> Report of the Inter-Society Council for Radiation Oncology | <input type="checkbox"/> American College of Radiology | <input type="checkbox"/> Substance Abuse and Mental Health Services Administration |
| <input type="checkbox"/> Other: Specify _____ | | |

- B. Provide a brief summary of how the Applicant plans to meet the guidelines related to this proposal.
- C. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

- D. Provide a copy of the related Quality Assurance plan

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- | | |
|--|--|
| <input type="checkbox"/> Energy conservation | <input type="checkbox"/> Group purchasing |
| <input type="checkbox"/> Reengineering | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.) | |
| <input type="checkbox"/> Other (identify) _____ | |

7. Miscellaneous

- A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

- B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

8. Financial Information

- A. Type of ownership: (Please check off all that apply)

<input type="checkbox"/> Corporation (Inc.)	<input type="checkbox"/> Limited Liability Company (LLC)
<input type="checkbox"/> Partnership	<input type="checkbox"/> Professional Corporation (PC)
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Other (Specify): _____

B. Provide the following financial information:

- i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.
- ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	\$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify: _____	
Total Capital Expenditure	\$
Medical Equipment (Lease (FMV))	\$
Imaging Equipment (Lease (FMV))	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	\$
Capitalized Financing Costs	
Total Capital Expenditure with Cap. Fin. Costs	\$

* Provide an itemized list of all non-medical equipment.

12. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name	\$ _____
---------------------------------------	----------

Available Funds	
Contributions	\$
Funded depreciation	\$
Other	\$

☐ Grant:

Amount of grant	\$
Funding institution/ entity	

☐ Conventional loan or

☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	\$
CON Proposed debt financing	\$
Interest rate	%
Monthly payment	\$
Term	Years
Debt service reserve fund	\$

☐ Lease financing or

☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	\$
CON Proposed lease financing	\$
Fair market value of leased assets at lease inception	\$
Interest rate	%
Monthly payment	\$
Term	Years

☐ Other financing alternatives:

Amount	\$
Source (e.g., donated assets, etc.)	

13. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS or TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

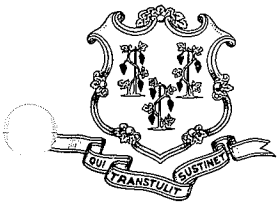
*Includes managed care activity.

B. Provide the following for the financial and statistical projections:

- i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.
- ii) The **assumptions** utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).
- iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS



M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 5, 2005
Linda Hayes
Executive Director
CareNet Pregnancy Center of Northeast CT
157 Main Street
Danielson, CT 06239

Re: Letter of Intent, Docket Number 05-30425-LOI
CareNet Pregnancy Center of Northeast CT
Establish Primary Care Clinic
Notice of Letter of Intent

Dear Ms. Hayes:

On July 19, 2005, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of CareNet Pregnancy Center of Northeast CT ("Applicant") to establish primary care clinic, at a total capital expenditure of \$30,500

A notice to the public regarding OHCA's receipt of a LOI was published in *The Norwich Bulletin* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

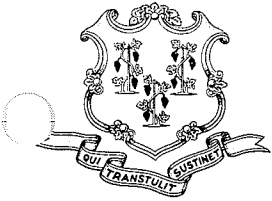
A handwritten signature in cursive script that reads "Kimberly R. Martone".

Kimberly R. Martone PF
Certificate of Need Supervisor

KRM:PF:dpd

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS



M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 5, 2005

Requisition # HCA06-040
FAX # (860) 489-6790

Norwich Bulletin
66 Franklin Street
Norwich, CT 06360

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Tuesday, August 9, 2005.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in cursive script that reads "Kimberly R. Martone".

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:dpd

c: Kathy Howe, OHCA

PLEASE INSERT THE FOLLOWING:

Pursuant to Section 19a-638 of the Connecticut General Statutes, the Office of Health Care Access ("OHCA") has received a Letter of Intent to file the following Certificate of Need application:

Applicant: CareNet Pregnancy Center of Northeast CT

Town: Danielson

Docket Number: 05-30425-LOI

Proposal: Establish Primary Care Clinic

Total Capital Expenditure: \$30,500

The Applicant may file its Certificate of Need application between September 17, 2005 and November 16, 2005. Interested persons are invited to submit written comments to OHCA regarding the Letter of Intent or the Certificate of Need application, when it is submitted by the Applicant. Such comments should be directed to:

Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent may be obtained from OHCA at the standard copy charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant. A copy of the Certificate of Need application may then be obtained from OHCA at the standard copy charge.

Confirmation Report - Memory Send

Time : Aug-05-2005 10:55
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number : 851
Date : Aug-05 10:54
To : 98604896790
Document pages : 002
Start time : Aug-05 10:54
End time : Aug-05 10:55
Pages sent : 002
Status : OK

Job number : 851

*** SEND SUCCESSFUL ***



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

August 5, 2005

Requisition # IICA06-040
FAX # (860) 489-6790

Norwich Bulletin
66 Franklin Street
Norwich, CT 06360

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Tuesday, August 9, 2005.

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If there are any questions regarding this legal notice, please contact Paolo Fiducia at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:dpd

c: Kathy Howe, OHCA